FACE INVESTIGATION

SUBJECT: Farmer Dies Following Fall Down Silo Chute and After Striking a Motor and a Pulley.

SUMMARY:

A 60 year old male farmer (the victim) died after falling down a silo chute and striking his head against a pulley and motor. The silo was located at the end of the dairy barn and the silo room connected the silo and the barn. The farmer had apparently climbed up the silo chute to repair the silo unloader. A pail of tools which contained a chain taken from the unloader and a trouble light were found by the body. The farmer was wearing bulky boots and there was wet haylage on the steps of the ladder. It is assumed that these conditions along with having a pail in one hand may have caused the farmer to slip and fall down the chute. Hair on the pulley and motor at the base of the chute, a gash in the back of the victim's head and a broken spinal vertebrae at C-2 provide evidence of a fall and a blow as the cause of death. The victim was working alone at the time of the incident, he was last seen alive at 10:00AM. Relatives found the victim at 8:30 PM and called for emergency services. First responders arrived within minutes, found no signs of life and called the police to investigate the death. Police arrived, photographed the scene and arranged to meet the coroner at the funeral home. The coroner pronounced the victim dead at the funeral home. The Wisconsin FACE investigator concluded that, in order to prevent similar occurrences, farmers should:

! **Develop, implement and enforce a comprehensive written safety program that includes but is not limited to a survey of all work processes and equipment on the farm.**

INTRODUCTION:

On December 12, 1992 a 60 year old farmer died after suffering a neck fracture following a fall from a silo chute. The Wisconsin FACE investigator was notified of the fatality by the Wisconsin Department of Industry Labor and Human Relations on January 11, 1993. On June 8, 1993, the Wisconsin FACE field investigator conducted an investigation of the incident. The incident was reviewed with the victim's sister on the farm where the incident occurred. Photographs of the incident site were taken. Copies of the death certificate, sheriff's report and the county coroner's report were obtained.

The victim had been a farmer his entire working life and had been on the farm of the incident for 40 years. There was no written safety policy or safety program but the sister who farms on a nearby farm said that the farmer had performed this type of work many time before. The victim's brother died in a logging incident on this farm years ago.

INVESTIGATION:

On the day of the fatal incident, the farmer had spoken to a visitor to the farm at 10:00AM. No one was working with the farmer and he was not seen again until 8:30 PM when the farmer's body was discovered by his nephews at the bottom of the silo chute. According to his sister, the farmer had been having trouble with his silo unloader. It appears that he climbed up the ladder to work on the unloader and somehow slipped either on his ascent or decent. The coroner found rub marks on the ladder guard where accumulated haylage had been rubbed off perhaps from the fall. The ladder appeared to be intact to the extent the investigator could determine from the ground. The coroner surmised that the farmer had fallen " at least 10 feet, landing in a small pile of haylage at the bottom. The haylage cushioned the fall but I believe his feet slid out from under him, causing him to fall backwards, striking his head on the motor and pulley, snapping his neck." The coroner reported that the combination of wet haylage and bulky boots may have caused him to slip and that there was no indication of heart attack, CVA or electrical shock. When the nephews found the victim an ice cream pail with tools and a broken chain inside nearby and the cord to a trouble light was laying across his legs. The nephews called for emergency services immediately and within minutes first responders and police arrived who made arrangements to transport the body to the funeral home where the coroner made the official pronouncement of death. The death certificate indicates that the injury may have occurred at approximately 12:00 noon.

CAUSE OF DEATH: The death certificate listed the immediate cause of death as fracture of C-2 at junction with C-3.

RECOMMENDATIONS/DISCUSSION:

Recommendation # 1: Employers should develop, implement and enforce a comprehensive written safety program that includes but is not limited to a survey of all work processes and equipment on the farm. Use the survey results to identify hazards and remove them.

Discussion: In this case, the fall may have been prevented had a safety survey identified the hazard of climbing the ladder with items in one hand or both. It appears that the trouble light and the pail with tools were carried by the worker as opposed to having them secured in a tool belt. Additional hazards regarding working alone at heights may have been identified. Working with someone on tasks identified as high risk or at a minimum arranging for a periodic check in at the site may have influenced the outcome.